

EXHIBIT A

**IN RE: NEW ENGLAND COMPOUNDING PHARMACY INC.
PRODUCTS LIABILITY LITIGATION**

PLAINTIFF PROFILE FORM

IMPORTANT - DO NOT FILE THIS DOCUMENT WITH THE COURT

Please provide the following information **TO THE BEST OF YOUR ABILITY** for each individual making a claim related to exposure to New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center (“NECC”) products. You will need to submit this Profile Form to the address below by _____ 2014 at 4:00 p.m. (prevailing Eastern Time) or within 60 days of filing your Complaint if you have not already filed it.

- “You” used in this Profile Form means the person who was exposed to NECC Products.
- “Product” means any medication or solution compounded by NECC.
- In filling out any section or sub-section of this Profile Form, please submit additional sheets as necessary to provide complete information.
- If, at a later date, you learn that any of your responses are incomplete or incorrect, please submit the correct information as soon as you become aware of it. In addition, supplemental information and documentation will likely be requested after you submit this initial Profile Form.

In completing this Profile Form, you are considered to have done so under oath. You must provide information that is true and correct to the best of your knowledge, information, and belief. If information is not known, remembered, or available, please indicate that in the appropriate location.

You may and should consult with your attorney when completing this Profile Form. If you are not represented by counsel or otherwise are unable to furnish any of the information requested, PLEASE PROVIDE AS MUCH OF THE INFORMATION AS YOU CAN.

Please Do Not Contact the Court With Any Questions or for Additional Information

I. CASE INFORMATION

1. Name of person who was injured or died (first, middle name or initial, last), including maiden or other names used:

-
- a. Were you (or the person identified above) administered the steroid methylprednisolone acetate from NECC?

Yes No Do Not Know

- b. Were you (or the person identified above) administered another NECC Product?

Yes No Do Not Know

If yes, please identify the product: _____

2. If the person completing this Profile Form is doing so in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor) ("Representative"), please complete the following:

- a. Name (including maiden name or any other names used) of person completing this form:

- b. Relationship to person making claim (e.g., spouse, child, guardian, etc.):

- c. Address of the Representative:

- d. Identify which individual or estate the Representative is representing, and in what capacity the Representative is representing the individual or estate (e.g., guardian, administrator, executor, etc.).

- e. If appointed as Representative by a court, please identify the court and date appointed:

- f. If the Representative is representing a decedent's estate, please state the date of death, the address where the decedent died, and the cause of death and attach a copy of the death certificate and autopsy report if available:

3. Please check the injuries sustained as a result of exposure to the NECC Product(s):

- a. Death
- b. Fungal Meningitis
- c. Arachnoiditis (persistent nerve pain)
- d. Phlegmon (persistent nerve pain at base of spine)
- e. Osteomyelitis (infection in bone, including vertebral or diskitis)
- f. Sacroiliitis (pain at base of spine)
- g. Peripheral Joint Pain (at site of injection)
- h. Septic Arthritis
- i. Epidural Abscess
- j. Stroke or stroke like symptoms (Cerebral Vascular Accident)
- k. Lumbar Puncture (Spinal Tap), Subsequent Treatment
- l. Lumbar Puncture (Spinal Tap), No Subsequent Treatment
- m. Infection of any kind, describe if known:
- n. Injection only, no symptoms or treatment
- o. Other (describe): _____

(Attach additional sheets if necessary to describe.)

4. Did you or anyone on the injured person's behalf initiate any lawsuit or civil action based on the exposure to an NECC Product? Yes No

If Yes, please state:

- a. Case Caption: _____
- b. Court and Docket Number: _____
- c. For the Attorney Representing You:

Attorney Name: _____

Firm Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Email Address: _____

*****The Rest of This Form Requests Information About The Person Exposed to the Product*****

II. EMPLOYMENT INFORMATION

5. Are you claiming to have lost money in the past (e.g., past lost wages) or will in the future (e.g., lost earning capacity) (other than for payments for medical care) because of your injuries?
- Yes No
6. If you answered "Yes" to Question 5 or you are not sure, then list the following for each employer you have had since January 1, 2004:

Name	Address	Dates of Employment	Occupation/Title

7. If you claim to have lost more than \$25,000 in your response to Question 5, please provide:
- Your annual income at the time of the injury/injuries alleged above to have been caused by your exposure to the NECC Product: _____
 - Your annual income presently: _____
 - The total amount of gross income you claim to have lost as a result of injuries you associate with your exposure to the NECC Product: _____.
 - An explanation as to how you calculated the amount you claim to have lost.

 - Do you claim that you continue to lose income due to the claimed injury?

8. Have you ever served in the military, including the military reserve or national guard?
- Yes No
- If so, when and what branch? _____
 - If you were ever discharged for anything other than honorable discharge, please explain as best you can the reason for your discharge:

III. INSURANCE/DISABILITY

9. Have you ever received a social security disability (SSI or SSD) award for a permanent disability? Yes No

If so, to the best of your knowledge please state:

Year claim was filed: _____

Nature of disability: _____

Approximate period of disability: _____

10. In the last ten years, have you received short-term disability benefits for a period of more than 60 days or applied for long-term social security disability (SSI or SSD) benefits? Yes No

If so, to the best of your knowledge please state:

Year claim was filed: _____

Nature of disability: _____

Approximate period of disability: _____

11. Have you filed a disability claim with any local/state/federal agency? Yes No

If Yes, when? _____

12. Have you filed a disability claim with any private insurance company? Yes No

If Yes, when? _____

13. Have you ever filed a worker's compensation claim? Yes No If so, to the best of your knowledge please state:

Year claim was filed: _____

Nature of claim: _____

Approximate period of disability: _____

14. Other than this lawsuit, have you (1) ever filed any other lawsuits for any reason or (2) in the last ten years settled or made a written demand for payment relating to a claim for bodily injury?

Yes No

If so, state to the best of your knowledge the court in which such action was filed, case name and/or names of adverse parties, and a brief description of the claims asserted.

15. Did you have medical insurance for treatment you received as a result of your exposure to any NECC recalled product?

Yes No

a. If Yes, please provide the following information for each insurance company. If more than one, please provide information for all:

Name of Health Insurance and/or coordinator of benefits:

Policy Number: _____

Name of Subscriber: _____

b. If you have Medicare or Medicaid coverage, please state your ID number, unless it contains your Social Security Number, in which case you should replace your Social Security number with "Xs" (e.g., B4-XXX-XX-XXXX-A5):

c. Has any insurance company asserted a lien on your recovery?

Yes No Don't know

If Yes, please provide the name and address of the entity asserting the lien: _____

IV. BACKGROUND AND FAMILY INFORMATION

16. Social Security Number (*Last 4 digits ONLY*): XXX-XX-_____
17. Date and Place of Birth: _____
18. Sex: Male Female
19. Driver's License Number and State of License: _____
20. Identify your current address and each address at which you have resided since January 1, 2004, and list when you started and stopped living at each one:

Address	Dates of Residence

21. Describe your educational history using the chart below, including the institution attended (even if not completed) (e.g., name of high school, name of college, name of technical school, *etc.*), the dates attended, your courses of study, and diplomas, degrees, or certifications awarded:

Institution	Dates Attended	Course of Study	Diplomas or Degrees

22. As an adult, have you ever been convicted of or plead guilty to a felony or a crime of fraud, dishonesty, or moral turpitude? Yes No

If so, describe where, when and the felony and/or crime. _____

23. Are you married? Yes No.

If so, please state:

Name of spouse: _____

Spouse's date of birth: _____

Spouse's current employer/occupation: _____

Date of marriage: _____

24. Do you have children?

If so, please state their names and ages: _____

25. Has your spouse or any other family member filed or made a claim for loss of consortium in this action?

Yes No

If so, state the name of your spouse or family member(s) filing the loss of consortium claim and their relationship to you. _____

26. To the best of your knowledge, did any child, parent, sibling, or grandparent of yours suffer from any of the following:

	Yes	No	Don't Recall
a. High cholesterol	____	____	____
b. Hypertension/high blood pressure	____	____	____
c. Diabetes	____	____	____
d. Neuropathy	____	____	____
e. Thyroid disorder	____	____	____
f. Arthritis/joint pain	____	____	____
g. Chronic pain	____	____	____
h. Autoimmune disease (including HIV, AIDS, or Crohn's disease)	____	____	____
i. Myocardial infarction (MI), heart attack, or other heart disease	____	____	____
j. Stroke or transient ischemic attacks (TIAs)	____	____	____
k. Chronic obstructive pulmonary disease (COPD) or other respiratory disease	____	____	____
l. Liver disease or jaundice	____	____	____
m. Metabolic syndrome	____	____	____
n. Enlarged prostate	____	____	____
o. Arteriosclerosis (hardening of the arteries) or other vascular disease	____	____	____
p. Osteomyelitis	____	____	____
q. Spinal abscess	____	____	____
r. Cirrhosis	____	____	____
s. Hepatitis	____	____	____
t. Kidney failure (end stage renal failure, dialysis)	____	____	____
u. Depression	____	____	____

V. MEDICAL INFORMATION

27. Date(s) you were administered or used an NECC Product:
-
28. Name of hospital or clinic or physician's office where you were administered the NECC Product:
-
29. Name of the individual health care provider(s) who administered NECC Product:
-
30. For what medical condition(s) did you receive the NECC Product (e.g., osteoarthritis, back injury, etc.)?
-
31. If you claim to have experienced symptoms or injuries from the administration of the NECC Product, (1) when did you first experience symptoms and (2) what symptoms did you have?
-
32. Have you been tested for meningitis or fungal infection? Yes No
- a. If Yes, provide:
1. Name, city, and state of hospital or clinic where tested:

 2. Date(s) of test(s):

 3. Type of test(s):

 4. Result(s):

33. Are any of the conditions you describe in response to Question 3 still affecting you?
 Yes No
If so, please describe how they are still affecting you:

34. If you are claiming that you suffered injury due to exposure to an NECC Product or may in the future, please state:
- a. Has anyone diagnosed you with a condition caused by an NECC Product? Yes No
 - b. If so, what is the name and address of the health care provider who diagnosed you?

 - c. What did they tell you or your representative?

d. Did you suffer from this injury at any point prior to the exposure to NECC Product?

Yes No

If so, please describe, including when and who diagnosed you in the past with this same injury or condition.

35. Has any health care provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you identified in response to Question 3 are due to exposure to an NECC Product? Yes

a. If so, who? _____

b. What did they tell you or your representative? _____

36. Do you claim that your exposure to an NECC Product made a condition(s) that you already had or had in the past worse? Yes No

If so, please explain how you allege the NECC Product made the injury or condition worse:

37. Are you claiming mental and/or emotional damages because of exposure to the NECC Product?
 Yes No

a. Did you receive treatment? Yes No

b. If so, please complete the table below regarding this treatment.

Name of Treatment Provider	Address	Date(s)	Diagnosis and Treatment

VI. COMMUNICATIONS WITH HEALTH CARE PROVIDERS

38. Do you remember any communication that you have had with a health care provider or a health care provider's employee or representative related to the NECC Product?

Yes No

If so, please describe, to the best of your ability, each communication with a health care provider employee(s) or representative(s) related to the NECC Product, including (but not limited to) with whom you communicated and when the communication occurred:

VII. MEDICAL BACKGROUND

39. What is your height? _____

40. What is your weight? _____

41. Smoking/Tobacco Use History: In the past ten years, have you ever been a regular smoker?
 Yes No If so, please complete the table below:

Time Period	Packs per Day

42. Alcohol Use: Has there been a time in the past ten years when you consumed an average of 10 or more drinks per week? Yes No

If so, please complete the table below:

Time Period	Drinks per Week

43. **Illicit Drugs:** In the past ten years, have you regularly used illicit drugs Yes No

If so, please complete the table below:

Time Period	Describe your drug use

44. Have you been diagnosed with any form of immune disorder (including HIV/AIDS) or autoimmune disorder (including, but not limited to, lupus, Inflammatory Bowel Syndrome, Crohn's disease, ulcerative colitis, mixed connective tissue disease)? Yes No

If so, please provide the following information:

Condition	Date Diagnosed	Diagnosing Physician

45. To the best of your knowledge, since January 1, 2004, have you ever been diagnosed by a doctor or other health care provider as suffering from:

	Yes	No	Don't Recall
a. High cholesterol	____	____	____
b. Hypertension/high blood pressure	____	____	____
c. Diabetes	____	____	____
d. Neuropathy	____	____	____
e. Thyroid disorder	____	____	____
f. Arthritis/joint pain	____	____	____
g. Chronic pain	____	____	____
h. Autoimmune disease (including HIV, AIDS, or Crohn's disease)	____	____	____
i. Myocardial infarction (MI), heart attack, or other heart disease	____	____	____
j. Stroke or transient ischemic attacks (TIAs)	____	____	____
k. Chronic obstructive pulmonary disease (COPD) or other respiratory disease	____	____	____
l. Liver disease or jaundice	____	____	____
m. Metabolic syndrome	____	____	____
n. Enlarged prostate	____	____	____
o. Arteriosclerosis (hardening of the arteries) or other vascular disease	____	____	____
p. Osteomyelitis	____	____	____
q. Spinal abscess	____	____	____
r. Cirrhosis	____	____	____
s. Hepatitis	____	____	____
t. Kidney failure (end stage renal failure, dialysis)	____	____	____

	Yes	No	Don't Recall
u. Depression	—	—	—

46. To the best of your recollection, have you taken any of the following medications since January 1, 2004:

	Yes	No	Don't Recall
a. Narcotic pain relievers	—	—	—
b. Analgesics	—	—	—
c. Non-steroid anti-inflammatory agents	—	—	—
d. Muscle relaxers	—	—	—
e. Over-the-counter (non-prescribed) pain relievers	—	—	—
f. Disease-modifying agents (<i>e.g.</i> , monoclonal antibodies, such as Enbrel)	—	—	—
g. Steroids of any kind (including gluco-cortico steroids)	—	—	—
h. Fungal medications (<i>e.g.</i> , methotrexate)	—	—	—
i. Injectable products of any kind: Please specify:	—	—	—

**VIII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES
OF INFORMATION**

List the name and address of each of the following:

47. As best you can, for all health care providers (e.g., doctors, nurse practitioners, therapists, psychiatrists, etc.) who treated you since January 1, 2004 (including treatment or therapy for mental or emotional health), please provide the following:

Name	Address	Approximate Treatment Dates	Diagnosis and Treatment (e.g., knee surgery for torn ACL; primary care for high blood pressure; child delivery)

48. For each hospital, clinic, or health care facility where you received treatment (inpatient or outpatient) since January 1, 2004, please provide the following:

Name	Address	Admission Dates	Reason for Admission

49. For each pharmacy that dispensed medication to you since January 1, 2004, please provide the following:

Name	Address

50. Are there any health care providers who have provided care or treatment to you since January 1, 2004, that you have not yet identified in this Plaintiff Profile Form? If so, please do so now:

Name	Address	Dates of Treatment

IX. DOCUMENTS

Please produce any of the following documents and things that are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers. Please attach all non-privileged documents and things to your responses to this Profile Form.

1. Death certificate, if applicable, as requested above.
2. Autopsy report, if applicable, as requested above.
3. All documents constituting, concerning or relating to product warnings or other materials provided to the individual exposed to the NECC Product or his or her agents, representatives or anyone acting on his or her behalf (other than those provided by your attorneys) in connection with the exposure to the NECC Product.
4. All documents relating to exposure or any alleged health risks or hazards related to exposure to the NECC Product in your possession at or before the time of the injury alleged in your Complaint (other than those provided by your attorneys).

VERIFICATION

I declare under penalty of perjury that the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in this Plaintiff Profile Form, as required above.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in some material respect incomplete or incorrect.

Signature: _____

Printed Name: _____

Date: _____